The Garamendi Plan
for Workers' Compensation Reform

Insurance Commissioner John Garamendi is committed to working closely with the Legislature to devise the solutions necessary to bring California's workers' compensation system back to the historic bargain of 1913 —a no-fault system that protects employers from liability and compensates injured workers equitably and efficiently. Below is a list of the problems affecting California's workers' compensation system and the proposed legislative solutions that the Commissioner believes are necessary to generate immediate, quantifiable, and concrete reform of the system.

Medical Cost Containment

Medical Fee Schedules

Problem: The current workers' compensation medical payment system is unnecessarily complex, costly, difficult to administer and often outdated. Key components of the workers' compensation medical system - specifically outpatient surgery centers - are still unregulated and are placing extreme cost burdens on the entire system. Uncontrolled and unpredictable inflation of workers' compensation medical costs is one of the system's primary cost drivers and a central cause of escalating workers' compensation premiums in the State.

While the number of claims have continued to decline in recent years, medical costs have continued to spiral out of control. From 1997 to 2002, medical costs per claim increased by 125%, rising from $13,845 to $31,120 per claim. By comparison, national medical inflation grew by 22% and average indemnity benefits per claim by 32% over the same period. This medical cost inflation has a strong negative impact on insurance companies' reserves and surplus and consequently the overall financial health of insurance companies.

Solution: Establish medical fee schedules for all parts of the workers' compensation medical system and index them to 120% of Medicare fee schedules which will help contain medical costs and bring stability and predictability to the workers' compensation system.

Stability and predictability allow actuaries to predict costs and insurance companies to correctly price their premiums. Our current fee schedule is not tied to Medicare, and is not updated and does not accurately reflect cost of care. Current law expects a state agency with inadequate funding and little experience to create and update complex medical fee schedules. Experience has proven it does not work. For example, the current Department of Industrial Relations (DIR) official medical fee schedule has not been updated for five years, effectively making it irrelevant and obsolete. The State's budget crisis has also jeopardized DIR funding to complete the pharmacy fee schedule called for in AB 749.

Tying costs to the Medicare fee schedule makes sense. It will provide a payment standard, allow for consistent and timely updates to the fee schedules and lead to additional cost savings through lower administrative costs on implementing and updating the schedules. Building on Medicare as a base, an exceptions process can be established for those medical services that can prove the Medicare schedule does not provide sufficient compensation. Language comparable to SB 228 which requires comprehensive Medicare-indexed fee schedules for all areas of the workers' compensation system must be an essential element of any meaningful reform plan. An extensive study of SB 228 by the California Commission on Health and Safety and Workers' Compensation (CHSWC) conservatively estimates it will save employers, local government, and the state of California more than $1.2 billion annually.

Concrete reform requires indexing the fee schedules to Medicare. Charge-based fee schedules in alternative legislation would not produce any savings to the system. Charge-based fee schedules would create the illusion of worker's comp reform without in any way affecting the medical cost inflation that is destroying California's worker's comp system. We strongly oppose such measures.

Legislation: SB 228 (Alarcon)

Repeal of the Treating Physician Presumption

Problem: AB 749 repealed the presumption of correctness of the treating physician only for injuries occurring on or after January 1, 2003.

Solution: The treating physician's presumption should be repealed for all injuries including those that occurred before January 1, 2003. The result would be a savings of approximately $2 billion to reserves, thus improving the financial health of the insurance industry. This would encourage more insurers to write workers' compensation insurance, create a more competitive market, and put downward pressure on rates. The savings effects accident years prior to 2003.

Utilization Management

Problem: Numerous interstate comparisons and California-specific studies have demonstrated that overutilization of medical treatment is a serious problem within California's workers' compensation system. While California's price per medical service is comparable to other states, California far exceeds other states in both the number of services per visit and visits per claim. Overutilization of medical services is a major cost driver that does not necessarily aid injured workers, extends injury claims, and wastes medical treatment resources.

Solution: Implementation of a comprehensive fee schedule will lead to savings, but without accompanying effective medical utilization controls, such savings will be eroded. We propose adopting a workers' compensation medical utilization structure that includes evidence-based clinical treatment guidelines, a strong definition of "medical necessity" and a streamlined independent evaluation process. Such a program would significantly reduce delays in medical treatment to injured workers and litigation over medical treatment disputes. We recommend using the American College of Occupational and Environmental Medicine (ACOEM) guidelines as the default interim guidelines until the Department of Industrial Relations develops an official utilization schedule. These evidence-based clinical practices guidelines, accompanied by a strong definition of "medical necessity", should be the standard for determining what treatments and procedures are supported by the workers' compensation system because such evidence-based practices or treatments have been proven to produce the best outcome for patients.

In order to address individual patient differences and to accommodate advances in medical science, it is important to include an independent examination process composed of medical professionals, so that treatments exceeding the guidelines can be evaluated and approved where appropriate. The independent examination process would allow workers' compensation medical decisions to be made by medical practitioners. While the evidence-based clinical guidelines would be the accepted standard of treatment, the examiner would consider new or additional scientific evidence of efficacy to approve a treatment that exceeds the guidelines.

Legislation: Commissioner's Language – Utilization Review, SB 757 (Poochigian) [Official Utilization Schedule]

Generic Drugs

Problem: Use of brand name drugs and high dispensing fees in the workers' compensation system places excessive costs in the system.

Solution: Existing law requires pharmacies to provide the generic equivalent of a name brand drug, when filling a workers' compensation prescription, unless (1) there is no generic drug equivalent available, or (2) the prescribing physician has specifically provided otherwise in writing. Proposed legislation would close a loophole in last year's generic-drug legislation (part of AB 749) by extending the generic-drug-dispensing requirement, currently imposed on pharmacies, to hospitals, clinics and physicians, when filling workers' compensation prescriptions.

Legislation: SB 223 (Margett)

Workers' Compensation Delivery System

Immediate Medical Treatment

Problem: For countless reasons, injured workers are routinely denied the immediate, essential, and, often times, basic medical treatment they are entitled to under the workers' compensation system. In 9 out of 10 cases, the injured worker is ultimately granted the medical care they or their physician initially request. These unnecessary delays in medical treatment lead to unnecessary costs (increased medical, indemnity, and litigation) as untreated workers' medical conditions worsen, they take much longer to return to work, and they seek legal counsel to resolve the issues.

Solution: The employer will be responsible for providing immediate medical treatment to all injured workers. Employers will have up to one year to deny a claim as opposed to the current 90 day period and can deny a claim for fraud at any time. Employers will be responsible for all medical treatment until the claim is denied.

Claims Handling

Problem: Inefficient claims handling contributes greatly to claims staying open longer and increased and unnecessary litigation in the system. A large percentage of claims handlers are overworked and underprepared to do their job. The overwhelming majority of participants in California's workers' compensation system believe that higher and more consistent standards for claims examiners through certification and training would greatly contribute to more efficient benefit delivery and reduced costs throughout the system.

Solution: (1) Establish certification standards and continuing education requirements for claims examiners to improve the consistency and quality of claims handling, (2) provide more and better training resources for claims examiners.

Legislation: AB 1262 (Matthews) – Commissioner Sponsored

Unfair Claims Practices Regulations/Prompt Pay

Problem: There are credible indications that insurance companies are not handling claims quickly or efficiently enough, thus leading to higher claims costs due to increased medical utilization and higher than necessary rates of litigation. In addition, there is an unduly high rate of litigation between insurers and medical providers over medical payments. This is likely due to delays in payment.

Solution: Commissioner Garamendi is initiating a process to include workers' compensation insurance companies in the fair claims practices regulations under Insurance Code Section 790 et seq., that regulates unfair or deceptive trade practices.

Irrational Penalty Structure

Problem: Penalties should have a reasonable relationship to the violation. The current penalty structure is irrational by allowing penalties to be assessed against the species of benefit paid, both past and future, for the entire claim, rather than the specific amount that was either delayed or payment was refused. Consequently, in a case where $200,000 in medical benefits was paid, a late $10 payment on reimbursement for a prescription to an injured worker can result in a 10% penalty or $20,000. The current structure provides very strong incentives for allegations of penalties to gain larger settlements and unnecessary litigation.

Solution: Require injured workers and their attorneys to timely and specifically report when they believe employers have unreasonably delayed or refused to pay benefits. Allow for disputes on unreasonably refused or delayed benefits to be resolved without litigation and payment of an immediate, no fault 10% penalty based upon the amount that was refused or delayed. If the matter is disputed further, then allow for a larger 25% penalty on the amount in dispute or $500, whichever is greater, to be assessed. This would help create a more responsive and rational penalty structure that effectively deters the specific negative conduct of the insurer or employer. It would also significantly diminish the opportunity to allege unwarranted penalties and reduce unnecessary litigation and costs in the system. 5814 penalties should not apply to claims that have been inherited by the California Insurance Guarantee Association (CIGA).

Legislation: AB 1480 (Richman) [as amended 4/21/03, section 6], SB 457 (McPherson) [if amended]

Carve Outs and Alternative Dispute Resolution Systems

Problem: Currently, the only option most injured workers have, if they do not receive the prompt and appropriate medical treatment and benefits they are entitled to, is to pursue their grievance through the Workers' Compensation Appeals Board (WCAB). Not only does this lead to unnecessary delay in benefit delivery, but it often times leads to pointless and costly litigation.

Solution: Create more carve outs, alternative dispute resolution mechanisms, and ombudsman programs that provide injured workers with more options for resolving disputes without lengthy and costly litigation. Several carve out programs, specifically those with an ombudsman, have had demonstrated success in reducing the level of litigation, returning workers to work more quickly, and reducing the overall cost burden on the system. Carve outs that are requested by unions should be permitted and should be a permissive subject of bargaining. The minimum premium volume required to establish a carve out should be reduced from $250,000 to $50,000.

Fraud

Problem: The current culture of California's worker's compensation system is one where abuse and fraud are widespread and serve as a cost driver in the system. This culture must change. The high premiums, low benefits, and overall inequity of the current workers' compensation system contribute to an environment that is highly vulnerable to fraud. Workers' compensation fraud ranges from abusive and fraudulent provider billing practices (up-coding, unbundling, prescription billing, durable equipment, and services not rendered) and medical-legal mills to applicant and insider fraud. Numerous factors exacerbate and perpetuate workers' compensation fraud, including personal and business economic hardship, public acceptance of insurance fraud, and inadequate resources (manpower and funding) to investigate insurance fraud cases. Some insurance companies have also been derelict in their responsibility to fight fraud. The lack of uniform methodology and standards for assessing and reporting suspected fraud is a contributing factor.

Solution: The California Department of Insurance (CDI) is restructuring, re-energizing, prioritizing and coordinating its fraud and investigation units and seeking to improve its working relationship with district attorneys and other state, federal, and local law enforcement agencies with an emphasis on information sharing. As part of these anti-fraud efforts, CDI supports increased criminal penalties for false or fraudulent statements and activities in connection with workers' compensation claims. CDI is also developing new regulations to help

insurance carriers step up their anti-fraud efforts and become more effective in identifying, investigating, and reporting workers' compensation fraud. The Department is developing a work plan to increase the number of audits performed by the Fraud Division SIU (Special Investigations Unit) Compliance Unit and continuing with an aggressive outreach plan to educate the public on anti-fraud efforts and how to identify and report fraud. Finally, CDI is strengthening its working relationship with the Workers' Compensation Insurance Rating Bureau (WCIRB) to support the Department's anti-fraud efforts. This includes the WCIRB developing an effective special investigations unit, obtaining the same immunity from liability for reporting fraud that insurance companies have and supplying CDI with timely access to their data.

Legislation: AB 1578 (Vargas), AB 1099 (Negrete-McLeod), SB 354 (Speier), AB 1215 (Vargas)

Physician Referral

Problem: The physician referral process for injured workers is an area of potential fraud and conflict of interest with the temptation of some physicians to refer injured workers for services and treatment to an entity in which they have a financial interest.

Solution: Prevent physicians from referring workers' compensation patients to clinics in which the physician has a financial interest. Existing law already prohibits this practice in most cases. Proposed legislation would close a loophole which allows it for outpatient surgery clinics.

Legislation: AB 1579 (Cogdill), SB 899 (Poochigian), SB 354 (Speier)

Other Proposed Reforms

Permanent Disability

Problem: The current system for determining an injured worker's level of disability (PD, PPD, TD) is highly subjective and inconsistent leading to ever more litigation and unequal settlements in which small injuries get too much and serious injuries get too little.

Solution: CHSWC is nearing completion (August 2003) of an extensive study by the Rand Corporation that recommends a new, more objective method of determining the permanent disability of an injured worker.

Legislation: The Legislature should take immediate action on legislation to improve the current system once this study is complete.

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